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Good afternoon Senator Crisco, Representative Megna and members of the Insurance and Real Estate Committee. I am here to testify in support **of SB 417** AN ACT CONCERNING CONFERENCES BETWEEN HEALTH CARRIERS' CLINICAL PEERS AND HEALTH CARE PROFESSIONALS, **SB 418** AN ACT CONCERNING OFF-LABEL PRESCRIPTION DRUGS **and HB 6867** AN ACT CONCERNING HEALTH CARE PROVIDER NETWORK ADEQUACY. The timing of this hearing could not be better; today is MS Action day and these bills are a high priority for the multiple sclerosis society (as well as for many other patients with chronic illness).

Last year in SB 192 AN ACT CONCERNING THE QUALIFICATIONS OF CLINICAL PEERS FOR ADVERSE DETERMINATION REVIEWS we attempted to strengthen the required qualifications for clinical peers in adverse determinations. That bill passed the Senate but was not taken up by the House in the 2014 session; SB 417 this year attempts to address the same issue with a different tactic. This legislation would require that insurers offer providers the option of a peer to peer conversation in which the provider can make the case for coverage without this conversation being considered an appeal of an adverse determination. PA 13-3 made it clear that such a conversation is not an adverse determination and allowed for these conferences. It is my understanding that some insurers have put this option to good use while

others have not. It is my hope that the insurers will work in good faith such that a change in the definition of clinical peer will not be necessary. In order for this process to work, the insurers must grant to the clinical peers that they make available, the authority to reverse the denial of coverage. They should also provide a clinical peer in the same specialty as the treating physician.

SB 418 would adopt the National Association of Insurance Commissioners model act on off-label use of drugs which differs from our current statutes in that it does not limit coverage by disease and allows evidence in medical literature to be a basis for coverage. The current language in our statutes regarding off-label use (38a-518b and 38a-492b) needs to be updated because the compendia in the statutes are out of date as some of them have merged or ceased to exist and none is readily available. These sections address off label use of prescription drugs only for patients with cancer or disabling or life-threatening chronic diseases. There is no medical evidence that would justify this restriction by disease type. SB 418 and the model act do not limit the coverage by disease, and most importantly they would expand the required coverage to drugs that have demonstrated efficacy in studies that have been published in peer reviewed medical literature.

Reimbursement for off-label indications of FDA-approved drugs is necessary to conform to the way in which appropriate medical treatment is provided, to make needed drugs available to patients, and to contain health care costs. Off-label prescribing is most commonly done with older, generic medications that have found new uses but have not had the formal (and often costly) applications and studies required by the FDA to formally approve the drug for these new indications. However, there is usually extensive medical literature to support the off-label use.

This legislation would require coverage for these drugs when there is proof of efficacy in the literature.

Other states have addressed this issue in a variety of ways. Among them is Tennessee which adopted the NAIC model act in 2010. The Centers for Medicare and Medicaid Services (CMS) allows for the use of peer reviewed literature in determining appropriate off-label use of drugs. The Veterans Health Administration and the Indian Health Service have broad language that allows for off label use. We should adopt this legislation in Connecticut; it would allow physicians rather than insurers to practice medicine and treat patients.

HB 6867 would require that insurers provide robust network adequacy that meets the comprehensive needs of enrollees. This legislation would ensure that patients are able to receive the medical care that they require in the specialty that is appropriate. HB 6867 requires the Healthcare Advocate and the Insurance Commissioner to assess and ensure network adequacy. This bill is another positive step for patient protection.

Thank you for hearing legislation on these important topics.